NOTICE OF INDEPENDENT REVIEW DECISION

May 8, 2002

Requestor Respondent

RE: Injured Worker:
MDR Tracking #: M2-02-0470-01
IRO Certificate #:

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ____ physician reviewer who is board certified in anesthesiology and pain management which is the same specialty as the treating physician. The ____ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 41 year old male has a history of back injury, status post a fall at work when he slipped on some oil on ___. He developed pain in the groin, left arm, and low back. The patient continues to complain of low back pain despite conservative treatment, which has included medication, chiropractic manipulation, rehabilitation and injection therapy.

Requested Service(s)

Open Coblation Nucleoplasty at L3-4 and L4-5

Decision

It is determined that the Open Coblation Nucleoplasty at L3-4 and L4-5 is not medically necessary.

Rationale/Basis for Decision

This procedure is not justified by the objective evidence seen on testing. The MRI shows chronic DDD with non-pathologic disc bulges only. There is no nerve root compression to corroborate bilateral leg complaints. EMG/NCV testing is non-diagnostic. The most recent discogram revealed only partially concordant pain at L3-4 and L5-S1. Moreover, previous independent evaluations have documented functional overlay and multiple positive Waddell signs, which contraindicate any further procedures or treatment. Finally, the mechanism of injury is not consistent with any disk injury.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code '148.3). This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code '102.4(h) or 102.5(d)). A request for hearing, along with a copy of this decision notice, should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, Texas 78704-0012.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,

cc: David Martinez, Chief Medical Dispute Resolution, Medical Review Division, TWCC

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this _____day of _____2002.

Signature of IRO Employee:

Printed Name of IRO Employee: